Parallel Process in Domestic Violence Services: Are we doing harm?

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This article proposes that the dynamics of domestic and family violence, those of coercion and control, may sometimes be unwittingly replicated in the interactional dynamics of individual services and the service system that works to address domestic and family violence. The author outlines some of the behaviour that may reveal this parallel and asks those in the sector to consider whether these are observable or familiar, before moving on to begin to propose ways to identify, name and address these dynamics.

Keywords: *Organisational dynamics, domestic violence, parallel process, teams*

Introduction

Parallel process is the idea that patterns or dynamics that arise in one context or setting are often reflected or played out in another (Searle, 1955). In the case of the welfare sector, this is the idea that some of the dynamics that arise in the lives and relationships of clients will play out within the teams and services working with those client groups.

Clinicians may or may not be aware of these dynamics, or of the parallel process concept. Even where there is such awareness, significant self-insight, emotional intelligence and reflective capacity can be required to uncover, rather than just play out, these unconscious replications. These ideas have been explored within therapeutic teams for some time. It is, however, the belief of the author that this same phenomenon can occur in case management or casework services, often with less attention paid to, and recognition of, the process.

This article will specifically explore the author's experience of, and experiences of witnessing, these dynamics in services working with victims of Domestic and Family Violence (DFV), to whom she provides supervision and consultancy.

Purpose

It is the intention of this paper to invite dialogue and discussion from the DFV sector about whether this phenomenon is as prevalent as it appears to be to the author, as well as to invite suggestions as to the best options for addressing this parallel process, where it is occurring, in case management and support services. While clinical supervision discussions and even informal discussions with those working in the domestic violence sector seem to illicit strong agreement that there is a wide prevalence of this parallel process, this paper is intended to invite domestic violence services and clinicians to dialogue and consider, to debate and refute, if appropriate, and to self-examine where necessary, with a view to co-creating a broader view of whether this phenomenon requires greater attention. This is so that clinician satisfaction and even safety, and ultimately, and most importantly, for clients, can be ensured.

Service Backdrop

Work with victims of violence, abuse and trauma is complex. Issues behind the dynamics can include transgenerational experiences of violence, and are often compounded by intersectional disadvantage such as poverty, disability, rigid or traditional gender roles and child protection concerns. Alongside clients who experience significant stressors, distress and compounding trauma, there are also often the competing needs of adults and children (for example to move or stay) to contend with.

Within DFV services, there is almost always more work than can be managed, with management of waiting lists and balancing of caseloads an area of frequent discussion and review. There are also often a range of agencies involved with each client, with potentially differing goals, agendas, timeframes and even philosophical frameworks. The different theoretical approaches or philosophical frameworks from which these agencies are operating are rarely openly acknowledged or even articulated. Different agencies, and even the clinicians within them, may have very different ideas about what the causes of DFV are, what their specific roles are and also how DFV should be addressed by that service. It is the view of the author that

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these differences are a part of the significant interagency tensions that can occur.

Within the DFV Sector, there are some clinicians and agencies which come from very strong feminist frameworks, where there can be historically justified mistrust of the motives, and potentially oppressive practices, of mainstream and government services. This was particularly necessary early on in the history of such services, when establishing the need for DFV services, like refuges. It was necessary then to convince others of both the extent and the risks of domestic violence. The primary approach that has developed from the early feminist framework foregrounds interventions that promote the empowerment of women, psycho-education of victims around the dynamics of violence, and active resistance to any who may be seen to oppress women, including child protection services.

There are other domestic violence services that are firmly rooted in therapeutic traditions. These see past trauma and oppression as something that requires clinical therapeutic intervention, which may include psychodynamic approaches, 'inner child' work or re-processing of trauma experiences. It is the author's experience these can be all encompassing approaches, involving fierce protection of women from the practitioner while the woman is given time to heal.

In more recent years, with a shift in the system toward addressing child protection issues in the context of domestic violence, and the broadening of the definitions of domestic and family violence to include male victims and a range of co-habiting relationships. With this, we have also seen the emergence of more case management services. Some of these services draw on feminist analysis as their primary mode of operation, and others see their role as whole family of family focused.

Then there has been the emergence of the men's behavior change programs and programs aimed at working with those using violence and / or control against their partners. Some of these programs, such as those that comply with the Minimum Standards set by the NSW Department of Attorney General and Justice (2012) are very well researched and sophisticated in their understandings of the potential causes of violence and can articulate their theoretical frameworks, while others could be described as almost 'backlash' programs, that are aimed at minimising or excusing men's violence through renaming the domestic violence as an 'anger management issue', and where there is a risk these programs are doing more harm than good' (Boxall, Rosevear, & Payne, 2015:3).

These various approaches have led to a diverse and varied domestic violence response sector, with inherent differences as to both the 'source' of the problem and of the 'solution'. This results in tensions that are played out between services, sometimes consciously, sometimes not. Tensions that can result in clients being caught up in the interagency crossfire. Morrison identified a similar phenomenon in child protection agencies (Morrison, 1999).

As early as 1977, Robert Dingwall identified the practice of 'Atrocity Stories' in which staff in agencies introduce new staff to the idea who 'we' collectively like, and who 'we' collective do not like. Stories are told of other agencies the clinician agency will work with, as well those which are found to be difficult or oppositional. These stories are shared usually before the clinician has had a chance to interact with these agencies and develop autonomous views. Some of these stories seem to predate experiences of any actual clinicians still with the services, and little is done to overcome these negative perception of others. Dingwall (1977) talks of the way in which atrocity stories serve to develop group cohesion – having a common enemy serves to join a group together. Yet this is not the healthiest way to create group cohesions, at others expense. It is also something that is often paralleled in the dynamics of DFV – cohesion and dependence in the relationship is in part created through isolation from others, stories of how the person using coercive control is the only one who 'really understands' the victim and the pointing out of the faults in others, all serves to alienate, isolate and create a greater loyalty 'back to base'. Healthier relationships, both interagency relationships and intimate partner relationships, are able to recognise that theirs is not the only way of seeing the world and others, outside the immediate sphere, have value to add and should not be regarded as an assumed threat.

Within the whole of the welfare service sector, a further complicating factor over the last few years has been the competitive environment, which often arises from funding systems. It is little wonder that some agencies in the sector behave like warring factions of the same extended family, each believes that they have the 'truth' on the family story and are unwilling to consider others points of view – they see this as necessary to their very survival. This is witnessed through the putting down of other agencies in an attempt to show only their own agency is worthy of receiving funding or is the only one doing things correctly, and yet it often reveals a level of self-interest and unprofessionalism (as well as another parallel process).

Parallel Process Concepts

While working at the psychodynamically influenced Tavistock and Portman Trust in the UK, the author started to reflect on the usefulness of the concept of parallel process to help make sense of past experiences of this phenomenon. Now, as a supervisor of a range of teams in the domestic and family violence sector, and an educator of even more, the experiences shared by colleagues has increased my own 'practice-based evidence' for the existence of a parallel process, that has led to this paper, which is aimed at inviting a broader discussion about both the presence, and influence, of parallel process in the sector.

Mothersole (1999) reviewed the literature on parallel process from its early mention by Searle (1955), and found that, although there are a few studies trying to prove its existence, there is substantial practitioner experience of it discussed in therapeutic circles (Mothersole, 1999).

It is also a concept that has resonated with so many practitioners when exploring the vicarious trauma of the work. It is rarely the 'sad' stories or awful narratives of our clients that cause us distress – they give us purpose, mission and a role (Reynolds, 2011). Rather, it is often the unprofessional practice, lack of integrity and truth in the practice of colleagues, experiences of minimisation of the reality of clients' experiences to fit the rhetoric or role of the agency, rather it is these more systemic issues that cause clinician trauma. Reynolds (2011) explores how it is often the systemic injustices that contribute to clinician stress and distress. It is the belief of this author that in the DFV sector, this stress and distress extends further, in that it is the experiences of power, control and oppression from supervisors, colleagues and other agencies – the playing out of DFV dynamics against each other through a parallel process – that causes

the most harmful and professionally confusing form of vicarious trauma.

As mentioned, Searles (1955:135) was one of the first to identify this parallel process, saying it is 'as if the therapist is unconsciously trying to tell the story of the client'. Ekstein and Wallerstein then built on this idea (1958:180) naming it a 'parallel process,' which they saw as a metaphor 'in which the patient's problem in psychotherapy may be used to express the therapeutic problem in supervision, and vice versa'. Kahn states that:

> "*Parallel process refers to the simultaneous emergence of similar emotional difficulties in the relationship between social worker and client, social worker and supervisor, and postulates a link between these two relationships, whereby emotions generated in one are acted out in the other.*" Kahn (1979:521)

Doehrman (1976) studied themes between supervisors and supervisees, and also supervisees and clients. He found the themes were observed to influence both up and down, proposing the reasons for this fall into two broad categories: identification and the adoption of reciprocal roles. These ideas may be old, but they still useful in highlighting and asking all clinicians and agencies to address, dynamics that may be unhelpfully transferred between clinicians and clients.

Boland (2006) is an Australian practitioner who has alluded to these processes, and draws on a family violence context. In her article comparing team functioning to that of families, she outlines a developmental systemic way of seeing the needs of clinicians in work places as similar to the needs of children in families in a number of ways:

> "*Adults working at the frontline in highly dysfunctional work systems share with all children the experience of comparative powerlessness in hierarchical systems. If exposed to similarly dysfunctional dynamics, we can come to respond in similar ways….this is one reason why the dynamics of some teams and organisations come to parallel the dynamics of the dysfunctional family systems with which they work.*" Boland (2006:24)

It is also not surprising, if we allow the idea of parallel process to be a possibility, that it should occur in the DFV sector. Part of the concept is that the more distressed a particular client group, the stronger the effects of the unconscious countertransference on staff, and the more likely client issues and dynamics will be repeated within the organisations (Sexton, 1999 cited in Webb, 2011:57).

Some of the parallel process possibilities in DFV services are outlined in the table below. The author would invite and encourage both critique and further identification of these possibilities.

Some of the potential parallels outlined in Table 1 draw on the work of Webb (2011: 59-60) who undertook a similar analysis of parallel process in post separation services. It is worth noting also that these behaviours take a toll, not only on the clinician (although this toll is significant),they also have a major impact on the client's experience of a service.

Table 1. *Potential Parallels*

DFV Dynamics	DFV Behaviours	Examples of Workplace Parallel Process
Power and Control	Patterns of violence, compliance through the use of power, abuse, denial minimisation Victim feels disempowered, unable to voice own needs Boundaries blurred and trust and capacity is diminished	Top down directives given to staff without chance for input or consultation Little consideration for impact of decisions on staff Rationale for decisions and processes not given to staff Unclear roles and responsibilities, confusion about tasks Limits on clinician autonomy Limits of access to information Micromanaging Managers or clinicians who won't or can't ever leave or retire – "we are the only ones who know how to do it" The push / pull where managers 'use' clinicians when useful, then push away
DFV Cycle "Walking on Esggshells"	Abuse cycle of violence	Staff describe walking on eggshells with management or colleagues who are unpredictable or explosive Changing of requirements and responsibilities - staff never sure of 'mood' Manager who shares inappropriate information/ uses staff as confidant, only to deny or misuse this
Over Responsability for Others	Victim adapts their behaviour and requirements to suit the person using violence / control and to not 'set off' abusive behaviours Victim denies or ignores own needs Feels a need to please and placate	Staff don't disclose their needs or requirements to manager for fear of response / burdening manager Staff take care to accommodate and not challenge those staff that 'go off' Staff placate others, including listening to the supervisors or colleagues own sense of martyrdom, or need to process and debrief, in a non-reciprocal way
'Parentified' Child	Child cares for parent, takes additional responsibility Child's own needs take a back seat to taking care of adults and reducing tension	Clinicians take on additional responsibility for reducing tension, calming others, including their manager Take on duties of higher levels of responsibility or position to keep the peace (without recompense or recognition) Agency may rely on competent staff to cover for managers or others not doing their job without addressing poor performance of others
Retaliation Violence	Fighting back after having enough of oppression	Emotional outbursts from staff who have 'had enough' Can result in inappropriate behaviour and disciplinary action Splitting and gossip about team members

Table 1. *Potential Parallels (Continued)*

DFV Dynamics	DFV Behaviours	Examples of Workplace Parallel Process
Person using violence / control knows best	Minimising and discrediting victims needs and views	Staff concerns are minimised or ignored Reduced sense of professionalism Imposed practice models with little capacity for reflective practice or consideration of alternative ways of doing things Blame of clinicians where management may have failed Individualizing of systemic issues as not coping Directive, rather than collaborative supervision and overly structured policies and procedures with little room for clinician professional judgment or input
'Gaslighting'	Phenomenon of convincing victim they are the unreasonable one, or going mad	Rather than an environment of continued learning, challenges to service processes are seen as a threat to be managed and questions are turned back on clinician Clinicians made to feel they do not have sufficient knowledge, understanding or experience in the sector Rumours about individuals aimed at discrediting and isolating them
Person using violence / control as savior and the true martyr	Some people who perpetrate violence truly believe they have the best interests of the victim at heart – they are protecting them and looking out for this person incapable of running their own life	Paternalistic and controlling management practices Patronising of new clinicians views and ideas by more established clinicians /managers Keeping people 'learners' in the workplace and discrediting their professional knowledge Comments like 'my team' or 'my girls know I look after them' Not acknowledging clinicians contributions and good ideas or taking as their own
Victim identification	Victim role becomes part of identity, unable to see another role in life Expects to be poorly treated / oppressed	Clinicians take on sense of incompetence and lack of agency for change React to professional feedback as criticism Develop sense of professional and often personal powerlessness Engage in Treat me don't beat me supervisory games (Cousins, 2011) Staff find it difficult to accept or trust fair treatment and may attempt "to provoke the fairest of managers into behaving in more familiar, that is punitive, ways, because this is what they have come to expect." (Boland 2006:25)
Enmeshed relationship	The level of confusion that is created through power and control dynamics, presented as 'for good', resulting in co- dependence	Nonverbal behaviour and affect is incongruent with verbal behaviour Scapegoating One staff member becoming the victim or problem child

Table 1. *Potential Parallels (Continued)*

DFV Dynamics	DFV Behaviours	Examples of Workplace Parallel Process
		Lack of appropriate professional boundaries, including intrusion of work relationships into personal life Clinicians caught up in workplace dynamics that they are unable to leave behind
Appeasement and protection of person using violence and / or control	Advocacy by victim on behalf of person using violence or control, making excuses for their behaviour	Try to predict and manage what will set colleague off Making excuses for their inappropriate behaviour and reactions, rather than holding them to account for consistent unprofessional behaviour Nurture and protect colleague or manager from realties of work Befriend supervisor or colleague through fear Clinicians do long hours to achieve recognition and there can be a culture of martyrdom
Isolation and splitting	Separating victim from supports, ensuring their dependence and reliance more wholly and solely on the person using control / violence	Reducing staffs sense of competence Atrocity stories that reduce inter-agency collaboration, increase competition and create isolationist practices Rhetoric that all other approaches / services than ours have flaws Sub groups and factions within the team fed and encouraged

This can arise in terms of the clinician's capacity and ability to function at their best, and regarding the reduction in services collaborating with each other for the client's best interests. Where this occurs, the author suggests there is an ethical imperative to address and shift these parallel processes. It is not at all acceptable that clients may suffer or receive a reduced service because of the professional systemic issues at play. When these issues are extreme, the author has witnessed that the focus can become clinician survival and the client focus can almost be 'lost' altogether.

Rock (2009:7) outlines how a perception of uncertainty, such as through being micromanaged or changing rules, can generate a threat response in the subordinate. He outlines how human brains are constantly attuned, usually at a subconscious level, to the ways in which social encounters threaten or support the capacity for choice. Where a clinician experiences a lack of control or agency, this has been shown to raise their stress levels. Nielsen (2010, cited in Webb, 2011:58) highlights the needs of clinicians in the helping professions to develop an awareness of their personal motivations, conscious and unconscious, and to examine these with a view to impact on the client work. The greater this insight, the better personal / professional boundaries are likely to be.

Effects when the hierarchical system is playing out these dynamics

It is the author's experience and contention that the most profound impacts on a professional's sense of competency is when either line managers or organisations collectively are not holding to the espoused values.

These values often relate to ideals such as empowerment, justice, integrity and strength based practice. Boland also outlines how the quality of the dynamics of hierarchical systems in the workplace, and whether they hold to the values espoused, can have a profound effect on clinicians (2006:22).

It is the author's observation that the sense of betrayal felt as a result of the difference between espoused agency values and the actual lived work experience in that agency, can be felt quite deeply and impact clinicians for years to come. Where agencies reveal quite a few of the dynamics listed in Table 1, the impact comes from not only being caught up in them, but from the disillusionment that the sector is 'supposed' to be above such behaviour. Webb states (2011:61) that the structure and culture of an organisation has an impact on how staff work and on the development of work practices and group norms. These have the potential to influence how parallel process is experienced and addressed.

Rock (2009) reports that neuroscientific study into the effects of workplace exclusion has shown that people who feel betrayed or unrecognised at work experience this as an actual neurological pain response. He goes on to explain that in the workplace, most of us learn to rationalise or temper our reactions to this lack of value, but there is an effect on our commitment and engagement. Both he and Boland consider the workplace as first and foremost a social system. Boland (2006: 22) states that it is "normal for individual professionals to yearn to feel valued, acknowledged and supported at work". She goes on to add that models of burnout often fail to recognise the systemic contributions to burnout, rather blaming the individual. There is a possibly ironic parallel process here, in that the DFV sector often tries to shift the responsibility away from the individual victim to highlight systemic patriarchy and gender imbalances as the factors which lead to DFV. At the same time, responses to individual clinicians and their 'failures' can still be very personal.

Bringing the process out into the open

Webb (2011:57) outlined that if organisations remain unaware of the phenomenon of parallel process, they are more likely to 'get caught up' in a 'similar state of mind' to their client group. While a central tenet of Boland's (2006:22) article on team functioning, is that the quality of dynamics in workplaces has a 'profound effect on the internal experiences of employees, and hence upon their professional functioning'.

Boland (2006:24) also predicts that reactions of individual clinicians will differ, that some staff will react with self-doubt, others will refuse new challenges and stick to old ways, while others still will "become jealously competitive with their colleagues, responding ungraciously to the success of others, attributing it to the favoritism of management, or to clever and unjustified self-promotion" (2006:25). In a similar vein, Obholzer (1994) outlines that splitting and denial are among the most commonly used defense mechanisms in institutions (cited in Webb, 2011:58), not just amongst families and clients. If any of these effects are at play, it becomes imperative to be willing to discuss and address them.

Ways to challenge the dynamics

One of the primary ways to address and challenge the phenomenon of parallel effect is first to not only identify the dynamics, but name them openly. Parallel process can be easier to predict and see in workplaces other than our own. Lemma (2003 cited in Webb, 2011:58) outlines how the self-reflective practitioner attempts to understand her or his own behaviour, and the behaviour of others, in terms of mental state (i.e., thoughts, feelings, intentions, motivations), while acknowledging that others may hold different perspectives of these behaviours.

Webb (2011:58) advocates listening for more than the 'content' of what is being said between colleagues about each other and the work. That is, listening for the feelings and beliefs behind this. She also suggests the need to reflect on the experiences of others we work with; clients, colleagues and (I would add), other agencies, in order not to just react, but to consider motivation and transference that has been triggered by some of these unconscious parallel processes.

Webb states that (2011:62) "Without the appropriate time, places and processes to support open reflection, clinicians face increased risk of 'acting out' unprocessed material…". Webb sees clinical supervision as fundamental to mitigating the risk of parallel process. This entails not just administrative supervision, and not just supervision for therapists. Case Managers and Caseworkers are being asked to work in increasingly complex situations and need just as much reflective capacity and time to ensure they are not contributing to, and reacting to, the complex dynamics at work in the clients and service delivery system. Webb states (2011:62) clinicians "require a safe place where they can present their work in its entirety, without fear of recrimination or disapproval. A space where the practitioner can feel heard, held and contained limits acting out of unprocessed material ".

So, on an individual level, finding a supervisory relationship in which these experiences can be acknowledged, examined and unpacked to consider their impact both on the clinician and on the client, is a start (although finding a safe space is often not all that easy). Similarly, safe group supervision may be able to offer this, but enough safety can be hard to establish, especially when dynamics are also at work. However, for this phenomenon to be truly examined and exposed requires teams and agencies to be brave and to find safe ways to consider and examine whether parallel process dynamics are at work in their agency and be honest about any such effects. Where ego can be loosely held, particularly by those with positions of organisational power, the ability to have open discussion is more possible. If feedback to those in power can be tolerated without the risk of future criticism or retribution, honest conversations can occur, but for subordinates, these conversations can be risky.

It is the author's proposition that it is likely that even in reading this article, some professionals have been able to see these dynamics in 'other workplaces' or in colleagues, but the next step, considering their own role in these processes, can be harder and is likely to create resistance, push back and defensiveness in some. It is crucial that practitioners take the time to reflect on such events and review the practice implications.

Organisations which use a reverse organsational chart, in which the clients are at the top, the frontline clinicians the next layer, and all other positions, whether managerial or support, are simply there to ensure the frontline clinicians are resourced to provide the services the client's need. With this focus, we can start to consider the importance of finding ways to move past workplace dynamics.

In healthy teams and partnerships there is respect. In workplaces this includes an appreciation of the unique contribution of different disciplines and treating all colleagues as having equal worth. In healthy relationships and teams there is a willingness to hear different ideas and opinions. In healthy workplaces, staff are recognised as the primary asset of a service, and effort is made

to maintain professionalism, professional development and growth, and high morale.

Rock (2009) uses neuroscience to outline that when leaders make people feel good about themselves, clearly communicate their expectations, give clinicians latitude to make decisions, and treat people fairly, this enables people to become more creative, open to ideas and effective. Ensuring respect and having clarity about expectations are crucial starting points for taking power out of the parallel processes.

Next steps

Webb (2011:58) suggests organisations put aside time to map common client challenges and behavioural patterns against the structural and behavioural responses of the organisation, she sees this as a strategy for promoting open reflection on parallel process. She also suggests 'listening well' to new staff who can often observe entrenched dynamics and patterns that staff are accustomed too. Webb finally suggests seeking the input of external advisors to bring alternative perspectives.

It is also worth noting and examining any existing 'atrocity stories' that exist and considering whether these require re-examining. We encourage our clients to be respectful and consider change, stating their concerns and naming issues, so it is imperative that we need to model this at an agency level. Whenever we are tempted to complain about or negate the contribution of another DFV service, we need to instead challenge ourselves to start a dialogue with that service and ensure that our differences in approach, or even understanding of each other, do not get in the way of client outcomes.

For some clinicians, the article will describe an environment that is all too familiar, and an organisational culture that is not yet ready to acknowledge the issues that have been canvassed or shift in the light of them. In these instances, it is the author's suggestion that another parallel process to client work is required. These clinicians may need to find a safe person with whom to do their own version of a safety plan, a plan to stay safe within their workplace; while they may possibly also plan to leave.

Conclusion

Where parallel process is occurring in DFV services, the impacts can be significant, both for the clinicians involved, and potentially on the clinical and service decision making. There is, therefore, an ethical imperative to consider whether this is occurring and for individual and agencies to actively hold this possibility in mind. This article is aimed at generating sector debate and discussion, as well as potentially being a tool for individual and service reflection on the phenomena of parallel process. The first step in addressing these dynamics will always be in recognising and naming their presence. Only after this has occurred can their power begin to be diminished.

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